# STIGMATISING SUICIDE

## Can our attitudes help prevent it?

| **Link:** | **The Samaritans** **http://www.samaritans.org.uk**<br>Telephone (24-hour national helpline) 08457 90 90 90 |
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In March 1941 Virginia Woolf set off across the water-meadows next to her home and drowned herself in the nearby river Ouse. Immediately before doing so she wrote the following letter to her husband Leonard (Woolf ,1969, see below):

*Dearest,*
*I feel certain I am going mad again. I feel we cannot go through another of those terrible times. And I shan't recover this time. I begin to hear voices, and I can't concentrate. So I am doing what seems the best thing to do. You have given me the greatest possible happiness. You have been in every way all that anyone could be. I don't think two people could have been happier till this terrible disease came. I can't fight any longer. I know that I am spoiling your life, that without me you could work. And you will I know. You see I can't even write this properly. I can't read. What I want to say is I owe all the happiness of my life to you. You have been entirely patient with me and incredibly good. I want to say that---- everybody knows it. If anybody could have saved me it would have been you. Everything has gone from me but the certainty of your goodness. I can't go on spoiling your life any longer.*
*I don't think two people could have been happier than we have been.*
*V*

(Woolf, L, 1969)

(Extract from THE JOURNEY NOT THE ARRIVAL MATTERS by Leonard Woolf published by Hogarth Press. Used by kind permission of The Society of Authors as the Literary Representatives of the Estate of Virginia Woolf. Copyright: permission to reproduce this section restricted to the Royal College of Psychiatrists' electronic website only).

Leonard's response has been described as follows: (Spater and Parsons, 1977, see below):

When lunch was ready and Virginia did not appear, Leonard found the notes she had left him. It was too late. By the time he reached the Ouse there was no sign of Virginia. Later that day, after all efforts to find her had failed, Leonard wrote a note which, creased and worn, was found among his effects when he died twenty-eight years later. It read:

*They said 'Come to tea and let us comfort you'. But it's no good. One must be crucified on one's own private cross.*

*It is a strange fact that a terrible pain in the heart can be interrupted by a little pain in the fourth toe of the right foot. I know that V. will not come across the garden from the lodge, and yet I look in that direction for her. I know that she is drowned and yet I listen for her to come in at the door. I know that it is the last page and yet I turn it over. There is no limit to one's own stupidity and selfishness.*

Extract from 'A MARRIAGE OF TRUE MINDS. AN INTIMATE PORTRAIT OF LEONARD AND VIRGINIA WOOLF' by George Spater and Ian Parsons Published by Jonathan Cape and Hogarth Press 1977. Used by kind permission of The Random House Group Limited. Copyright: permission to reproduce this section is restricted to the Royal College of Psychiatrists' electronic website only).

Each act of suicide is unique, and generalisations are dangerous. The fear of 'going mad' which featured large in Virginia Woolf's case probably occurs only in a very small proportion of suicides. Her death also occurred in unusual circumstances: it was wartime, with an imminent threat of invasion by Nazi Germany. Nevertheless, her letter vividly describes one particular example of the ultimate despair leading to suicide.

Initial reaction to her letter is likely to vary enormously: some may regard it as inevitable and even courageous; others will consider it a tragic and pointless loss which might have been prevented. But her letter sets the scene for this focus on our attitudes towards and prejudices about someone who is suicidal, and the part these feelings may play in suicide and its prevention.

## WHAT DO WE KNOW ABOUT SUICIDE?

About 5000 people in England and Wales kill themselves each year. Although rates in most age groups have fallen in recent years, they remain far too high. There have been strenuous efforts to lower them and to identify those most at risk.

It is important to keep a check on suicidal behaviour, not so much to know about what has passed, but to try to understand ways of preventing it in the future. For example, there are differences between the sexes, with a higher percentage of men than women killing themselves.

In the past suicide was more common in the elderly. Remarkably, this pattern has changed in recent years, not only in the UK but also world-wide. Suicide is now just as common in young adults; indeed, there are worrying upward trends, especially in young men.

Methods also vary, and are often related to availability of lethal agents and situations. At one time coal gas - putting one's head in the domestic gas oven - was common, but with the change from manufactured carbon monoxide-containing town gas to less toxic natural gas, there has been a large fall in numbers of suicides using this method. To some extent there has been a change towards using car exhaust as a means of suicide.

There has also been an increase in the use of hanging. Guns are used much more frequently in the USA, whereas in the UK this method is rare except in rural situations where guns are more easily available. It would seem that reduced availability of dangerous agents may prevent some suicides. In the UK the sale of paracetamol in much smaller packs than previously is a promising move in this direction. It is by studying such information that methods of prevention can be introduced.

Suicide rarely happens 'out of the blue', but is usually part of a more general mental disorder - often one which can be treated if it is recognised and dealt with. The most

common type of mental disorder associated with suicide is a depressive illness (see www.changing minds.co.uk website for more information) but greatly increased risk is also associated with schizophrenia, alcoholism, substance abuse, dementia and, especially in the long term, with eating disorders: some increased risk is associated with all other kinds of mental illness.

Physical illness, particularly long-term disabling conditions such as severe arthritis, stroke and multiple sclerosis, may also be an important risk factor for suicide. Perhaps surprisingly, cancer is not as common a cause as might be expected.

Stressful life events like social isolation, recent bereavement, job loss or other serious changes in personal circumstances may also be triggers for suicide. These crises may affect individuals differently, and the more important factor may be the way in which the person copes with the problem. A constructive approach may help one distressed person, while another may succumb to despair. Helping people to cope with stress may be an effective way of preventing some suicides.

Suicide is a pattern of behaviour which, though not common, can sometimes be prevented and requires constant awareness on the part of professional and non-professional helpers alike, as well as informed awareness by the public in general. It is by non-judgemental action, based on understanding and awareness, that help can be provided for people in distress and the number of fatalities reduced.

## WHAT IS IT LIKE TO BE SUICIDAL?

**How common are suicidal ideas?**
We all feel 'down in the dumps' at times. A surprising number (probably about 15%) of us occasionally get to the stage of thinking that life is not worth living, but such feelings do not usually last long and we soon brighten up again. Our concern here is with the much smaller number of people who actually go on to kill themselves.

**Are suicidal people mentally ill?**
It used to be thought that a considerable number of suicides were 'rational', where someone decides that life is not worthwhile and acts on this 'rational' decision. Evidence now suggests, however, that such 'rational' suicides, where there is no reason to suspect mental illness, form only a very small proportion of all self-inflicted deaths – probably no more than 7%.

It has been known, though rarely, for whole communities to kill themselves in one massive act of self destruction. Mass suicide may occur when a tightly knit group, intensely identified within itself either in terms of ethnic and or religious characteristics, is faced with an overwhelming external threat. The Jewish zealot community at Masada in A.D. 74, and more recently the Jones sect in Guyana, are two examples of this.

The precise state of mind of individuals involved in such group suicide is a matter for conjecture, particularly as there is some evidence that coercion may be involved. It seems inappropriate in such unusual circumstances to put mass suicide down to mental illness as we normally understand it.

Apart from such rare events, and the infrequent occasion when it appears to be a totally rational act, suicide in general is not an act which ‘stands alone’. As already indicated, for all practical purposes it is sensible to assume that it is associated with a wider problem, usually mental illness in one form or another. Moreover that, although depression is the most common of these, a whole range of other types of mental illnesses are associated with increased risk of suicide.

**The suicidal state of mind**

It is difficult to imagine the degree of despair associated with real suicide risk. Nevertheless we can get some idea by looking at the various symptoms. Insomnia is very common, and the person is usually emotionally upset in some way, most often depressed and/or anxious and agitated.

It is striking how often suicidal people, even to the very end, remain ‘in two minds’ about whether or not to kill themselves. This ambivalence means that there is usually an element of hope left. As a result, we should not be surprised to see marked fluctuations in the levels of distress and despair felt and shown by people who are contemplating suicide. At times, there may even appear to be nothing wrong.

Such variations in behaviour should not be taken as a sign that there is very little risk of suicide. Very often suicidal people are angry at others, or at their life situation. But the anger they feel towards others is also directed at themselves. So suicide risk should not be discounted merely because someone is behaving in a provocative or even aggressive way.

A few people decide to kill themselves a long time in advance. They make detailed plans, perhaps write a suicide letter, and then act. Such individuals may become calm and free from distress, probably due to the fact that all indecision and agonising over what to do are at an end. A solution has been found.

More often the act of suicide is impulsive, consistent with ambivalence and indecision. This explains why it is so important that we should be willing to reach out and engage with a person we believe to be suicidal. They may be engaged in an internal debate in which the highest possible stakes are involved.

## OUR ATTITUDES TOWARDS PEOPLE WHO ARE SUICIDAL

Attitudes of the past set the scene for those we hold today. Over the centuries the Church has regarded suicide as a sin: the body of a ‘suicide’ would be refused burial in consecrated ground, and personal property confiscated.

Yet the Romantic Movement of the 18th Century regarded suicide as a noble act. Until the Suicide Act of 1964, suicide in the UK was regarded as a crime, as was any attempt to take one's own life. Either way, suicide has clearly created strong feelings in others: and it is well recognised that powerful emotions are not the best basis on which to form a rational opinion.

Today’s attitudes towards suicide are still varied and strongly held. Probably only a minority take the view that the act of suicide is primarily a selfish one. Nevertheless,

there is some degree of doubt, even among mental health care professionals, about how appropriate or feasible it is to attempt to prevent suicide.

Most people, seeing someone in trouble or distress, would probably stop and offer help, or at least feel some sympathy and concern at the sight of a fellow human being's pain. But there are situations where this does not happen.

For example, we may feel that the person is exaggerating and not really suffering, or perhaps we conclude that they have brought the situation on themselves, like walking carelessly into the road. In cases like this we may give the person the benefit of the doubt and offer help, but perhaps somewhat grudgingly.

But when the stress is not obvious, or the situation is frightening because of the individual’s behaviour, sympathy evaporates and the person is labelled as 'mad' or 'crazy'. We no longer feel inclined to offer help, and understanding and tolerance disappear.

It is this automatic labelling and rejection, or STIGMA, which is so upsetting for the individual, their family and friends. Stigmatisation is particularly sad when it is directed at someone no longer able to answer back, the ‘suicide’.

Labelling someone as mad or crazy causes distress because it emphasises the problems that person faces, and in the case of a suicide, their apparent failure to deal with them. Stigmatisation also has a devastating effect on those left behind, whether family, friends or professional helpers who also ‘failed’. Moreover, it ignores mitigating social circumstances and life stress which may have been factors or triggers in the act.

## ETHICAL DILEMMAS

There are no simple answers to the ethical issues involved in suicide. Some people are satisfied with the view that individuals have responsibility for their own decisions and that no one has any right or obligation to interfere.

A religious person might well challenge such a concept, believing we are on earth at the behest of a Divine Authority, and we do not have the right to withdraw our labour in this way. A humanist might see suicide as selfish, believing that an individual has no right to opt out of the social responsibility we accept for each other.

But these different views presuppose that the person who killed him/herself was making a rational judgement unclouded by false perceptions or distortions caused by illness. However, if the decision was irrational, we may then challenge the right of the individual to act in this way without an opportunity for others to intervene to prevent it.

It would seem sensible for professional assessment to be made in all cases where it is clear that an individual is putting their life at risk, and still more so where others may also be at risk. In fact, many troubled people do seek professional help and advice rather than keep silent or refuse help.

Not everyone can accept that some individuals do, in fact, feel that life is no longer worth living and can seriously contemplate ending it, even telling relatives and friends, and, if the opportunity arises, professionals.

Too often people who talk about suicide are brushed aside with comments like, 'Don't be silly; you don't want to do a thing like that.' Why do we react in this way? It could be due to wilful ignorance or be a deliberate rejection; or, perhaps most commonly, a feeling of great discomfort that a member of our family or close friend can seriously entertain such ideas. Or it could be anger or frustration at someone's repeated threats to kill themselves so that we feel or say, 'Go on, then, why don't you get on with it?'

It is difficult to lay down clear rules about how we should respond to suicidal ideas or feelings which are clearly expressed, or even simply hinted at. Yet given all the available evidence about suicide and its prevention, we should conclude that it is wrong to dismiss thoughts or threats of suicide as play acting, imagination, fantasy or lunacy.

Instead, they should be listened to and taken seriously, if only by asking how the person feels and for how long have they have had these ideas. Perhaps our response should be similar to that we would make to a complaint of severe toothache, nightmares or redundancy or given evidence of some other self destructive behaviour such as an addiction, eating disorder or cigarette smoking. 'Tell me about it; it must be so worrying. Have you thought of seeing someone who knows a bit more about it than I do?'

## CHALLENGING NEGATIVE THOUGHTS ABOUT SUICIDE AND ITS PREVENTION

- *'The act of suicide is primarily a selfish one and shows no concern for the feelings of others.'*

The idea that suicide is primarily selfish does not take into account the severity of despair, and abnormal sense of hopelessness, which can occur in severe depression and other mental disorders frequently associated with suicide risk.

- *'A decision whether or not to kill oneself is a personal matter and each individual should be free to make it without reference to others.'*

The question 'whose life is it anyway?' often finds popular support. Yet surely we cannot generalise on this matter, if only because the mental state of the individual needs to be considered.

- *'Clinical review of suicide is undesirable because any good it might do is outweighed by the guilt feelings it generates in healthcare professionals when they fail to prevent it.'*

- *'A considerable number of people who kill themselves are reluctant to seek help before the event. It is therefore not feasible to prevent such suicides.'*

To ask for help is not unusual among people who go on to kill themselves. Almost half of them make contact with their GP or mental health services in the month before they die. Young men, however, present a particular problem, because they are far less likely than others to seek help before killing themselves. It is possible that asking for help, particularly on account of personal problems, is difficult for young men, who want to appear confident and even 'macho'. In addition, there is a general stigma attached to being emotionally vulnerable and possibly mentally unwell.

- *'When suicidal people discuss their problems with others before their death, their true intention is not clear. We cannot be expected to see through this 'disguise'.*

When people thinking of suicide do seek help before killing themselves, they are likely to be recognisably different from their normal selves. Doctors need the clinical skills to be able to recognise their true intention.

- *'It is not worthwhile healthcare professionals striving to acquire clinical skills in suicide prevention because it is too rare an event.'*

Doctors may believe that episodes of suicide are so rare that there is no point in developing skills to try to prevent them. Yet suicides are just as common as first episodes of ulcerative colitis or multiple sclerosis.

- *'Once a person gets into a suicidal crisis then suicide is inevitable and the process cannot be influenced by any kind of intervention.'*

It is common for people contemplating suicide to feel misunderstood and rejected in the days and weeks before they die. So it is important to be aware how alienated such people may feel, particularly in view of fact that they often seek help and may take a lead from our attitude to them. If we do not reach out to help them, their sense of rejection may become stronger, so that in not acting we may even contribute to their final decision to kill themselves.

- *'It is not possible to try to prevent suicide unless adverse economic and social conditions change for the better.'*

Undoubtedly suicide is often closely associated with stressful circumstances of many kinds which may be outside the individual's control. Yet surely it remains reasonable to try to help someone face circumstances of this kind and help to reduce/avoid suicidal despair.

- *'It is dangerous to open up the topic of suicide when face-to-face with someone who might be suicidal.'*

It is a commonly held view that we should avoid discussing ideas of wanting to kill oneself for fear that they will be acted upon. Such anxiety was presumably why a

letter from one GP accompanying a patient referred to a psychiatrist included the statement 'P.S. I've been careful not to raise the topic of suicidal ideas'. In fact nothing could be further from the truth. Sharing such ideas of despair in a sympathetic way is an important part of the process of relieving distress.

- *'When a person's life situation appears to be truly hopeless and impossible to face, suicide may be an appropriate act.'*

Who are we to decide that a person is better off dead? Our response to this fundamental question will depend on how we react to the facts about suicide and to the arguments outlined in this paper.

## WHAT SHOULD WE DO TO HELP PEOPLE WHO ARE SUICIDAL?

What needs to be done when we find ourselves face-to-face with someone who is at risk of suicide will depend upon the situation and our relationship with that person. A relative of someone at risk, though possibly having regular contact, might nevertheless find it particularly difficult to engage in discussion of suicidal ideas, or even to accept that a family member could feel that way.

A friend or colleague might also feel embarrassed at the prospect of discussing such personal and painful topics, and indeed may back off totally from doing so. Nevertheless, there are basic principles of helping which apply to everyone. It is important to remember that if we are to avoid stigmatising the suicidal, we should first closely examine our own attitudes and behaviour to make sure we are not prejudiced.

**Be sure that we know the basic facts about suicide.**
Stigma arises partly out of ignorance, which in turn can lead to prejudice. Each of us holds opinions and indeed convictions about many matters. Some of these opinions may be misguided and wrong: yet it may be extremely difficult for us to recognise this.

Our attitudes and behaviour towards such a controversial topic as people who feel suicidal are no exception. So at least we ought to ensure that we know the basic facts about suicide.

**Examine our own attitudes.**
We may be too sceptical about the possibility of preventing suicide. Examining our attitudes is therefore critical, as they will dictate our general approach to someone at risk of suicide. If our attitudes are negative, especially if intensely so, we need to step back and search within ourselves to decide whether they are really based on fact and can be justified objectively. Otherwise we are at risk of holding on to irrational feelings and stigmatising ideas.

**Be willing and able to provide 'First Aid' for a suicidal person**
Being face-to-face with an actively suicidal person is a dramatic experience. To start with, it is crucial to realise that such a person is likely to be acutely aware of our attitude and, being very mixed up about whether or not to end it all, is seeking a lead

from us.  We have the opportunity either to rekindle their hope or to increase their despair.

Our own doubts about being able or willing to help greatly diminish the chance of encouraging the person to live. Lack of concern, perhaps arising out of failure to realise how serious the risk is, or a rejecting attitude on our part is likely to increase their sense of despair.

Sometimes, when a situation seems hopeless and we say so, we may become involved in a collusion with the person contemplating suicide without our realising it. To them we may seem to be confirming their despair, possibly with disastrous effect on any chance of preventing their suicide.

Comments on suicide being ‘admirable’ in certain circumstances have the same effect and never rekindle hope.  A view that ‘suicidal people will always kill themselves in the end’ is also quickly picked up by the person at risk.  Yet in reality rarely is any situation hopeless. It is quite astonishing how often things that appear so can eventually resolve, particularly with the right sort of help.

Sometimes we mistakenly convince ourselves that we should not even reach out to a person who is suicidal and try to provide the equivalent of ‘First Aid’, failing to realise that effective help can depend on very basic and simple things.  By First Aid we mean engaging with, providing initial support and helping the person at risk to seek more specialised assistance. Our failure to show positive concern is yet another way in which people considering suicide may feel stigmatised.

The most important basic skill involves being willing to listen and talk to that person – probably in that order. The Samaritans have long demonstrated the value of listening; it is tempting to say 'just listening', but this would greatly undervalue its significance and potential in providing help. There is much to learn about how to listen effectively, but the essential ingredient of doing so with care and concern for the individual at risk should be something we can all do. Even this important basic approach has at times been stigmatised as representing no more than 'tea and sympathy'.

The Samaritans have also made clear the importance of ensuring that help is immediately available at all times through their 24-hour telephone service. It is often when alone at night that despair can strike hard and unexpectedly: Then people who are suicidal need us to listen to them. The Samaritans developed such a service first for the public, but more recently they have extended their role to prisons and hospitals.

Their approach underlines the basic worth of anyone who experiences suicidal despair, including the belief that an individual who consults them should have free choice concerning their decisions and actions. Such emphasis on freedom of personal choice often encourages clients who contact the Samaritans to think positively about themselves and even seek further help rather than kill themselves.

In other situations, free choice cannot always be assumed, as for example when mental illness leads to temporary impairment of insight and judgement. Mental health care professionals often have a major dilemma in deciding how best to fulfil their professional responsibility to act in the best interests of mentally ill patients who are suicidal.

**Emphasise the value of suicide prevention whenever the need arises**
We need to feel confident that much can be done, using even simple techniques, to help suicidal people to feel that life is worth living. If we do have such conviction and confidence, then we will want to take issue with others who, without good evidence, express negative and perhaps even hostile views on suicide and its prevention.

We should challenge such comments as, 'He's going to do it anyway sooner or later', or, 'If I were in his situation, I would do it'. Similarly, we should be alert to negative processes in society, for example bullying in schools, at work or in prison, that can cause severe distress to people and lead them to contemplate suicide.

## CONCLUSION

Positive and well-informed attitudes can help to prevent suicide. On the other hand, a negative, rejecting approach may increase the chance that a suicidal person will choose to die. We must always remember that most people contemplating suicide are very often ambivalent. Our reaction to them may – literally – make all the difference between life and death.

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**in consultation with THE SAMARITANS.**

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**Links for further reading**

"Stigmatisation and suicide" article by Simon Armson, Chief Executive, The Samaritans, in Every Family in the Land: understanding prejudice and discrimination against people with mental illness. www.stigma.org/everyfamily/sarmson.html

"Suicide and attempted suicide" factsheet for parents and teachers in "Mental Health and Growing Up", The Royal College of Psychiatrists.
www.rcpsych.ac.uk/info/mhgu/newmhgu29.htm

Bereavement Information Pack for those bereaved by suicide or other sudden death, by Kate Hill, Keith Hawton, Aslog Malmberg and Sue Simkin, The Royal College of Psychiatrists. www.rcpsych.ac.uk/publications/gaskell/bereav/index.htm